REDACTED - 8/2003

First Quarter 2000 Summary of Incidents, Complaints, Enforcement Actions

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¡ NOTE: Items within these summaries have been redacted (blackened out) due to confidential medical information under the Medical Practice Act and The Texas Public Information Act.

"Any complaints and or incidents involving hospitals on or after August 30, 1999 are not releasable under the Texas Public Information Act & The Health and Safety Code Chapter 241.051 (d). The text of these summaries will not appear in this report."

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http://www.tdh.state.tx.us/ech/rad/pages/brc.htm

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SUMMARY OF INCIDENTS FOR FIRST QUARTER 2000

I-7558 - Stolen Nuclear Gauge - Terra-Mar, Inc. - Fort Worth, Texas

On January 3, 2000, the Licensee notified the Agency of a stolen nuclear density gauge. A pickup truck, containing the gauge, was not returned from a work site on December 30, 1999. The driver/operator was also missing. The vehicle, with the gauge and other tools, was reported stolen to the Ft. Worth Police Department. On January 4, 2000, the truck, with the gauge inside, was found parked outside the Licensee's Dallas office. The gauge was leak tested with no leakage detected. The gauge was returned to service. The Licensee terminated the driver/operator's employment..

File Closed.

I-7559 - Misadministration - University of Texas Health Science Center San Antonio (UTHSCSA) - San Antonio, Texas

On January 6, 2000, the Registrant notified the Agency of a [redacted] misadministration that occurred as the result of a dosimetry error at the Cancer Therapy and Research Center (CTRC). Agency investigators determined that the dosimetry was miscalculated because the [redacted] was selected by the Radiation Oncology Computer System (ROCS) when [redacted] was not manually selected. The resulting calculated [redacted] time of [redacted] resulted in a treatment dose greater than [redacted] of the prescribed dose. The late discovery of the misadministration was due to the failure of CTRC to follow internal procedures and perform required comparative calculations within 3 days of delivery of one-half of the prescribed dose. After discovery of the misadministration both the referring physician and the patient were notified of the error. The dose delivered [redacted]. The patient [redacted] Follow-up examinations will be performed on [redacted] alternating between UTHSCSA and CTRC. The CTRC has made the following changes to prevent recurrence of a similar event: 1) The ROCS at both facilities administered by CTRC have been changed to default to a dummy source, requiring the entry of the proper isotope before calculations can be performed; 2) the dosimetrist will be required to indicate in large print on the isodose representation the radionuclide selected for the procedure, prior to signature by the prescribing physician; 3) a second manual calculation will be performed by a staff physicist before one-half of the dose is delivered; and 4) the treatment plan will be hand carried by the dosimetrist to the physicist designated to perform the manual calculations. If the designated individual is absent, a back-up physicist will perform the calculations. If that individual should also be absent the treatment plan will be delivered to the Director of Medical Physics who will ensure a review is performed.

File Closed.

I-7560 - Radioactive Material Found - Structural Metals, Incorporated - Seguin, Texas

On December 28, 1999, steel mill notified the Agency that radioactive material had been detected in a load of scrap metal. An industrial smoke detector was segregated from the scrap. A Licensee took possession of the source and identified it as 1.6 microcuries of radium-226. There were no serial numbers on the device that would allow it to be traced back to the owner. The company that originally manufactured the device is no longer in business. The scrap metal company arranged for disposal of the device.

File Closed.

I-7561 - Radioactive Material Stolen - Petra Technologies Incorporated - Houston, Texas

On January 10, 2000, the Licensee notified the Agency of the theft of a nuclear moisture density gauge during the hours of darkness on January 9-10, 2000. The gauge had been stored in the front seat of the operator's truck, under a blanket, while parked at his apartment complex. The vehicle was broken into and the unsecured gauge, along with other items, was stolen. The Licensee was cited for failure to secure the radioactive material from unauthorized removal.

File Inactive.

I-7562 - Equipment Malfunction - Union Carbide - Port Lavaca, Texas

On December 9, 1999, the Licensee notified the Agency of an equipment malfunction that occurred on December 5, 1999. A source cable stop on a gauge fell off its mounting position, pulling a source below its normal operating position. The lower position created a slightly higher than normal radiation field in the area around the source. Exposures to workers were minimal. The Licensee's investigation revealed the lock nut that holds the stop in place was missing. A lock nut was added to the unit. To prevent a recurrence, a check of the lock nut was added to the routine inspection.

File Closed.

I-7563 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7564 - Radioactive Material Found - Structural Metals, Incorporated - Seguin, Texas

On January 11, 2000, the scrap metal company notified the Agency that a 1.7 microcurie radium-226 source was segregated from a load of scrap on September 7, 1999. There were no serial numbers or other identifying markings that would allow the source to be identified or traced to an owner. An authorized Licensee analyzed and took possession of the source for disposal.

File Closed.

I-7565 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7566 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7567 - Overexposure - Radiographic Specialists Incorporated - Houston, Texas

On January 24, 2000, the Licensee notified the Agency of a 5,985 millirem exposure to a radiographer during the 1999 monitoring period. An Agency investigation confirmed the exposure. The investigation could not determine any instances of reported off-scale pocket dosimeters, separation of the film badge from the body during radiography, unintentional or deliberate exposure of the film badge, or any instance when the radiographer's alarming rate meter actually alarmed during radiography operations. Film badge records of two co-workers who had worked with the radiographer during all jobs conducted during the period had badge readings of only 125 millirem and 195 millirem respectively. The investigation could not determine the cause of the exposure. The Licensee was cited for allowing an employee to exceed the annual whole body occupational dose limit.

File Closed.

I-7568 - Overexposure - Technical Welding Labs - Pasadena, Texas

On January 21, 2000, the Licensee notified the Agency of a 5,071 millirem whole body exposure to a radiographer during the 1999 monitoring period. An Agency investigation determined the

exposure resulted from long work hours during the last month of the year. The radiographer averaged 100 hours per week at various temporary job sites. During some exposures, the radiographer was unable to maintain adequate distance from the source. After learning of the excessive dose, the Licensee temporarily assigned the radiographer to work not involving radioactive material. To prevent a recurrence, the Licensee began weekly audits of job performance, increased safety meetings to twice weekly and stressed keeping exposures as low as possible. The Licensee was cited for the violation.

File Closed.

I-7569 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7570 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7571 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7572 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7573 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7574 - Overexposure - GCT Inspection - South Houston, Texas

On February 14, 2000, the Licensee notified the Agency of a 5,205 millirem whole body exposure to a radiographer during the 1999 monitoring period. An Agency investigation determined the radiographer received 3,430 millirems of the total exposure during the September 15, 1999, through October 14, 1999, monitoring period. The radiographer could not recall any unusual activity that led to the exposure. He did not work excessive hours, his pocket dosimeter did not go off-scale, and his alarming ratemeter did not alarm. The Licensee was cited for the exposure and for failure to return the monitoring device to the processor within fourteen days after exchange.

File Closed.

I-7575 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7576 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7577 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7578 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7579 - Stolen Portable Nuclear Gauge - HTS, Inc. - Houston, Texas

On February 8, 2000, the Licensee notified the Agency of the theft of a portable nuclear gauge. The chain securing the gauge in the company vehicle had been cut and the transport box and the gauge were stolen. The gauge was recovered on February 12, 2000, approximately five blocks from the location where the operator had stopped for breakfast enroute to the job site.

File Closed.

I-7580 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7581 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7582 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7583 - Stolen Nuclear Gauge - Fugro-McClelland, Inc. - Fort Worth, Texas

On March 24, 2000, the Licensee notified the Agency that a moisture density gauge was stolen from a work site when the gauge was left unattended by the operator. The gauge was recovered three days later, when the finder brought the gauge to a rental company for an assessment of the value and was advised to turn the damaged gauge into the City of Arlington. The gauge was determined to have a broken source rod. The Nuclear Regulatory Commission was notified of the theft and recovery of the nuclear gauge. An Agency investigation determined that all sources were still in place in the gauge and no one was exposed to the gauge. The gauge was returned to the manufacturer for repair. The Licensee was cited for failure to secure radioactive material from unauthorized removal.

File Closed.

I-7584 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7585 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7586 - Equipment Damaged - Richmond Foundry - Richmond, Texas

On March 2, 2000, the Licensee notified the Agency that a 7.8 curie cobalt 60 radiography source could not be returned to the shielded position. During the performance of radiography inside a stationary bay, a steel block fell on the guide tube and crimped it, preventing the source's return to the shielded position. The source became lodged in a six foot extension tube. The radiographer secured the area, locked the bay, and notified the radiation safety officer (RSO). The RSO contacted an authorized Licensee to retrieve the source. Using remote handling tools and an overhead crane, the source was retrieved without further incident. The individual who retrieved the source received an 83 millirem whole body exposure and a 130 millirem right hand exposure. To prevent a recurrence, the steel block used for film identification was repositioned for greater stability.

File Closed.

I-7587 - Radioactive Material Lost - ALUMAX Mill Products, Inc. - Texarkana, Texas

On April 7, 2000, the Licensee notified the Agency that the facility was in possession of 250 microcurie polonium-210 static eliminators not authorized by their General License Aknowledgement. The radiation safety officer (RSO) was able to locate only 8 of 19 unauthorized sources that had been acquired by the facility. The RSO took actions to determine the origin of the unauthorized sources, collected all unauthorized sources found at the facility, attempted to locate any remaining unauthorized sources, stopped use of these unauthorized sources, and dispose of all unauthorized sources found. All sources were leak tested and disposed of on April 26, 2000. The missing anti-static sources are believed to have been inadvertently disposed.

File Closed.

I-7588 - Badge Overexposure - M.D. Anderson Cancer Center - Houston, Texas

On March 31, 2000, the Registrant notified the Agency of a 11,430 millirem exposure to a physician during the February 2000 monitoring period. The Registrant believes the personnel monitoring badge was worn with the film improperly loaded. The badge processor noted there were no filter patterns on the film indicating the film was exposed outside the holder. An Agency investigation concurred with the Registrant's findings. A deletion was granted and an assessment of 250 millirems, based on a recalculation for low energy and the use of a protective apron while using fluoroscopy equipment, was accepted.

File Closed.

I-7589 - Off Scale Dosimeters - Cooperheat- MQS, Inc. - Houston, Texas

On March 27, 2000, the Licensee notified the Agency that two radiographer's pocket dosimeters had gone off scale during radiography operations. The radiographers had been working with a 63 curie iridium-192 camera. Their personnel monitoring badges were submitted for analysis and indicated 300 millirem and 480 millirem whole body exposures. The Licensee's investigation determined that the source had not been returned to the fully shielded and locked position. The radiographers indicated that during the incident they did use an alarming rate meter. The Licensee was cited for the violations.

File Closed.

SUMMARY OF COMPLAINTS FOR FIRST QUARTER 2000

C-1447 - Regulations Violations - Industrial Nuclear Company, Incorporated - Houston, Texas

On January 21, 2000, the Agency received an anonymous complaint alleging that the Licensee did not have a radiation safety officer and did not document the receipt of iridium-192 sources. An Agency investigation substantiated the allegations. The Licensee was cited for these and other violations discovered during the investigation.

File Closed.

C-1448 - Regulation Violations - Paramount Event Services - San Antonio, Texas

On January 5, 2000, the Agency received an anonymous complaint alleging that a Registrant performed laser light shows not in compliance with Agency regulations. Allegedly, laser interlocks were broken; safety systems were bypassed; and the laser light was scanned too low during the show. The Agency monitored the set up of the lasers and the light show. No violations were noted.

File Closed.

C-1449 - Regulations Violations - Karnes County Corrections Facility - Karnes City, Texas

On January 6, 2000, the Agency received an anonymous complaint alleging that there was an unregistered dental x-ray facility in operation at the Karnes County Corrections Facility managed by the Wackenhut Corrections Corporation. A records review did not indicate a registration nor an application from the facility. An Agency investigation determined a dental x-ray machine had been in operation for over 3 years. The facility submitted an application December 23, 1999, that was received by the Agency January 3, 2000. In addition to not being registered, the facility did not have a posted technique chart, and had not performed an equipment performance evaluation required for dental equipment. A Certificate of Registration has now been issued. The facility was cited for being unregistered as well as the health related violations noted during the inspection.

File Closed.

C-1450 - Uncredentialed Technologists - MedCure PA - Houston, Texas

On January 11, 2000, the Agency received an anonymous complaint alleging that the Registrant allowed uncredentialed technologists to perform radiographs. An Agency investigation determined three technologists performed radiographs at the facility. Two were credentialed. The third technologist, had a certificate that expired on December 31, 1999, but had performed radiographs during January of 2000. The Registrant was cited for allowing an uncredentialed individual to operate the x-ray equipment.

File Closed.

C-1451 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1452 - Unregistered Laser - Humphrey's Salon/Malouf Dermatology - Irving/Ft. Worth, Texas

On January 13, 2000, the Agency received an anonymous complaint alleging that a facility was operating an unregistered laser. An Agency investigation determined the facility was not operating a laser. However, it was determined that a physician associated with the facility took referrals for hair removal procedures involving the use of a laser at another location. An investigation at the second location found a laser that was not registered That facility was cited for the violation.

File Closed.

C-1453 - Unregistered X-Ray Equipment - Island Medical Clinic - Port Aransas, Texas

On February 4, 2000, the Agency received an anonymous complaint alleging that an unregistered facility was advertising and performing x-ray services. An Agency investigation determined that the office was open and had an x-ray machine and operational processor. However, the x-ray machine was inoperative due to a malfunctioning timer. During the inspection no x-ray log nor films were discovered that would indicate use of the x-ray machine. The inspector informed the facility of requirements to register the equipment within 30 days of performing the first radiographs. The complaint could not be substantiated.

File Closed.

C-1454 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1455 - Unauthorized Use of X-Ray Equipment - MacGregor Medical Association - Houston, Texas

On November 13, 1999, the Agency received an anonymous complaint alleging that an x-ray machine designated for medical diagnostic radiography was used to perform unauthorized x-rays on a dog belonging to an x-ray technologist employed by the facility. An Agency investigation confirmed that a dog was x-rayed on August 7, 1999, in violation of the Registrant's authorized use for the equipment. In addition, two x-ray technologists held the animal during the procedure without the use of protective apron, gloves, or other shielding. The Registrant was cited for unauthorized use of an x-ray machine, failure to use appropriate protective devices, and an uncredentialed equipment operator.

File Closed.

C-1456 - Uncredentialed Technologist - South Texas Spinal Clinic - San Antonio, Texas

On February 16, 2000, the Agency received an anonymous complaint alleging that a Registrant allowed an uncredentialed technologist to perform radiographs. An Agency investigation determined the technologist is credentialed through the Texas State Board of Medical Examiners and is currently listed on the Non-Certified Technologist's (NCT) registry. However, the technologist performed oblique lumbar radiographs, a dangerous and hazardous procedure for which the technologist was not credentialed. Further, the technologist performed radiographs during January 1, 2000 through March 3, 2000 without a current NCT registry listing. The Registrant was cited for allowing a technologist to perform procedures without credentials and for allowing an NCT to perform dangerous or hazardous procedures.

File Closed.

C-1457 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1458 - Regulation Violations - McGregor Medical Association - Houston, Texas

On February 24, 2000, the Agency received an anonymous complaint alleging that processor quality control was not performed as required by regulation. An Agency investigation identified the following violations. The Registrant: failed to perform the image quality evaluation with the phantom at the correct time intervals; failed to establish valid operating levels for processor performance evaluation; and failed to cease performing mammography when the analysis of quality control tests, for phantom images, indicated the density difference limits were exceeded. The Registrant was cited for the violations.

File Closed.

C-1459 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1460 - Uncredentialed Technologist - Metro Imaging and Surgical Clinic - Dallas, Texas

On February 28, 2000, the Agency received an anonymous complaint alleging a Registrant allowed an uncredentialed technologist to perform radiographs. The Agency was unable to substantiate the allegation. The physician indicated that he operates the x-ray equipment and on occasion his medical assistant positions patients.

File Closed.

C-1461 - Uncredentialed Technologists - Heights Diagnostic Imaging Center - Houston, Texas

On February 24, 2000, the Agency received an anonymous complaint alleging that an uncredentialed technologist was performing computed tomography (CT) and an underexperienced mammography technologist was performing unsupervised mammograms. An Agency investigation determined that the CT technologist was credentialed and the mammography technologist did not perform unsupervised mammograms. The Registrant was cited for other violations found during the investigation.

File Closed.

C-1462 - Regulation Violations - X-Ray Inspection, Inc. - Pearland, Texas

On March 6, 2000, the Agency received a complaint alleging that the Licensee allowed radiographers to: share individual personnel monitoring badges; that one badge may have been deliberately "overexposed; that badges were not always returned to the processor in a timely fashion; and badges were not exchanged in a timely fashion. An Agency investigation determined badges were individually assigned and returned to the processor in a timely fashion. Personnel monitoring records indicated exposures were below regulatory limits.

File Closed.

C-1463 - Uncredentialed Technologist - Houston Medical Clinic - Houston, Texas

On March 8, 2000, the Agency received a complaint alleging that a an uncredentialed individual was taking x-rays and an individual was practicing medicine without state licensure. An Agency investigation determined that the massage therapist alleged to have performed x-ray procedures had left the facility three months prior to this investigation. The individual alleged to have been practicing medicine was available and was assisting a licensed physician at the facility. The Registrant was cited for failing to notify the Agency within 30 days of change of radiation safety officer.

File Closed.

C-1464 - Unauthorized Site - X-Ray Inspection, Inc. - Pearland, Texas

On February 25, 2000, the Agency received a complaint alleging a Licensee was storing radioactive material and operating a radiography business at an unauthorized location and had no radiation safety officer on site. An Agency investigation substantiated the allegations. The Licensee was cited for the violations.

File Closed.

C-1465 - Regulation Violation - Diagnostic Clinic - San Antonio, Texas

On March 9, 2000, the Agency received a complaint alleging a mammography facility was not providing mammograms for comparison upon request by another facility. An Agency investigation determined the company had declared bankruptcy and gone out of business on February 29, 2000. During the month of March 2000, the medical records were in transition. After March 31, 2000, a new procedure was put in place for obtaining films.

File Closed.

C-1466 - Unlicensed Source - Roxar Inc. - Houston, Texas

On February 7, 2000, the Agency received an anonymous complaint alleging an unlicensed company was processing and distributing radioactive material. An Agency investigation did not substantiate the allegations. The location was a sales office only and does not receive gauges at the location. Gauges sold by the office are shipped directly from the manufacturer to the customers. A radiation survey of the facility did not detect any radiation above background.

File Closed.

C-1467 - Uncredentialed Technologists - Childress Family Clinic, PA - Childress, Texas

On March 31, 2000, the Texas Department of Radiological Technologist Certification Program (MRT) notified the Agency that they had received an anonymous complaint alleging that the Childress Family Clinic, PA, had persons not listed as MRT, Limited MRT, or Non-Certified Technician (NCT) performing X-Ray procedures. An Agency investigation determined that for the period April 21, 1999, through April 22, 2000, two technicians, currently working under a newly issued hardship exemption, had performed X-Ray procedures at the facility. The facilities previous hardship exemption had expired April 20, 1999, and had not been renewed by the Office Manager, who had been terminated for cause. The facility was issued a Notice of Violation that had already been corrected by issuance of the newly issued hardship exemption.

File Closed.

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INCIDENTS CLOSED SINCE FOURTH QUARTER 1999

NO INCIDENTS WERE CLOSED SINCE FOURTH QUARTER 1999

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COMPLAINTS CLOSED SINCE FOURTH QUARTER 1999

NO COMPLAINTS WERE CLOSED SINCE FOURTH QUARTER 1999

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING THE FIRST QUARTER 2000

NO HOSPITAL OVEREXPOSURES WERE REPORTED DURING FIRST QUARTER 2000

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APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES
REPORTED DURING FIRST QUARTER 2000

Houston, Texas

Radiographic Specialists Incorporated 1

Pasadena, Texas

Technical Welding Labs 1

South Houston, Texas

GCT Inspections 1

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APPENDIX C

ENFORCEMENT ACTIONS FOR FIRST QUARTER 2000

Enforcement Conference: T.W. Bohannan, D.D.S. - Hurst, Texas - Dental

On January 14, 2000, an Enforcement Conference was held with T. W. Bohannan, D.D.S., P.C. Registrant representatives attending the conference were T. W. Bohannan, D.D.S., Wanda Bohannan, and Melissa Crow. Agency representatives attending the conference were Messrs. Quincy Wickson (Chair), Rick Munoz, and Thomas Caldwell and Madames Karan Rains and Cathy McGuire.

The conference was held as a result of the type, severity level, and repetitive nature of violations noted during an Agency inspection conducted at the Registrant's facility on August 17, 1999.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation dated September 16, 1999, and the responses to the violations, were reviewed by Ms. Karan Rains.

After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Agency will increased the Registrant's inspection frequency to every 2 ½ years instead of the routine inspection frequency of every 5 years.

2. It was recommended that a service company perform routine compliance tests at an increased frequency.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Castle Dental Centers - Houston, Texas - Dental

On January 25, 2000, an Enforcement Conference was held with Castle Dental Centers. Registrant representatives attending the conference were Donna D. Gained, Radiation Coordinator, Dr. Mash Amer., Regional Dental Director, Todd Busch, Regional Operations Director - Houston, and Steve Days, Regional Operations Director - Austin. Agency representatives attending the conference were Messrs. Quincy Wickson (Chair), Rick Munoz, Thomas Caldwell, and Ken Moon and Madames Jackie Carter, June Ayers, Cathy McGuire, and Jody Miller.

The conference was held as a result of the type, number, severity level, and repetitive nature of violations noted during Agency inspections conducted at the Registrant's facility and the failure of the Registrant to respond to the Notices of Violation in a timely manner.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notices of Violation, and the responses to the violations, were reviewed by Madames Jackie Carter and June Ayers.

After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Registrant shall submit to the Agency an updated radiation manual containing a set of operating and safety procedures, for Agency review, within 30 days of receipt of this memorandum.

2. The Registrant shall submit to the Agency a schedule indicating the due dates for routine compliance tests for each site within 30 days of receipt of this memorandum.

3. The Registrant shall establish a procedure to ensure 30 day responses for Notices of Violation, within 30 days of receipt of this memorandum.

4. The incomplete routine compliance tests will be redone to complete the missing data, within 30 days of receipt of this memorandum.

5. The Registrant must make the commitment that, if Ms. Donna D. Gained requires assistance to perform the tasks of Radiation Coordinator, this assistance will be provided.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Tenet Health Systems, dba: Brownsville Medical Center - Brownsville, Texas - Mammography

On January 27, 2000, an Enforcement Conference was held with Tenet Health Systems, dba: Brownsville Medical Center. Registrant representatives attending the conference were Mr. Frank J. Bolanos, Director of Radiology, Ms. Ruth Esquivel, and William McKinney, M.D. Agency representatives attending the conference were Messrs. Rick Munoz (Chair), Quincy Wickson, and Jerry Cogburn and Madames June Ayers and Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Registrant's facility and a significant, unacceptable deficiency in the application and overall effectiveness of the radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Jerry Cogburn and Ms. June Ayers.

After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Registrant shall submit, by February 7, 2000, an updated policy to establish procedures for cleaning and disinfecting mammography equipment.

2. The Registrant shall re-read 171 mammograms performed by Purnia L. Backlas, M.D., or submit, by February 7, 2000, documentation to verify the number of mammogram readings performed by Dr. Backlas. If the facility is not able to obtain the documentation or have the mammograms re-read within the time frame allotted, mammography patients must notified. If the time frame is too restrictive, the Agency must be notified in order to grant additional time. The documentation was submitted at the conference, reviewed, and approved by the Agency.

3. The Registrant shall submit, by February 7, 2000, an updated mammography medical outcomes audit program.

4. The Agency will increase the Registrant's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Michael A. Mantas, M.D., P.A., dba: Associated Medical Providers-Dallas, Texas - Medical

On February 8, 2000, an Enforcement Conference was held with Michael A. Mantas, M.D., P.A., dba: Associated Medical Providers. Associated Medical Providers representatives attending the conference were Michael A. Mantas, M.D. and Ms. Janice Robinson. Agency representatives attending the conference were Mr. Quincy Wickson (Chair) and Madames Debbie Borden, Jackie Carter, Cathy McGuire, and Angie Thompson.

The conference was held as a result of Associated Medical Providers' failure to adequately register x-ray equipment and to adequately respond to several attempts to obtain voluntary compliance.

The participants were introduced and the procedure for conducting the conference was explained.

The violation regarding the failure of Associated Medical Providers to register x-ray equipment, and the response by Michael A. Mantas, M.D., P.A., were reviewed by Ms. Jackie Carter.

After reviewing the violations and responses, Associated Medical Providers' representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. An Administrative Penalty in the amount of $1,000.00 will be assessed. The Preliminary Report for Assessment of Administrative Penalties will be received under a separate action.

2. Since a new Certificate of Registration has been issued, inspections will be conducted in accordance with the schedule for a new registrant.

3. The Registrant shall submit a written commitment to the Agency, within 30 days of receipt of this memorandum, that must include: a method for promptly handling correspondence and telephone calls from the Agency; the name(s) of the individual(s) responsible for ensuring that communication with the Agency is maintained and the individual(s) is\are to be knowledgeable in x-ray and Agency regulations, including the required response times; if a new radiation safety officer (RSO) is assigned, their qualifications must be submitted within 30 days of receipt of this memorandum; and if the duties of the R.S.O. is delegated to individuals at various subsites, these individuals must be aware of and trained in the responsibilities of an RSO, as described in 25 TAC §289.226.

After the caucus, Associated Medical Providers' representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Cogdell Memorial Hospital - Snyder, Texas - Medical

On February 15, 2000, an Enforcement Conference was held with Cogdell Memorial Hospital. Licensee representatives attending the conference were Messrs. Jeff Reecer, Administrator, and Brian Moffett, and Ms. Norma Adams. The representative attending the conference for Numed, Inc. was John Pickett. Agency representatives attending the conference were Messrs. Rick Munoz (Chair), Michael Dunn, David M. Wood, and Thomas Caldwell and Madames Karan Rains and Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during Agency inspections conducted at the Licensee's facility.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notices of Violation, and the responses to the violations, were reviewed by Mr. Michael Dunn and Ms. Karan Rains.

After reviewing the violations and responses, the Licensee's and Numed, Inc.'s representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Licensee shall submit a corrected copy of a Medical Physicist's report within 30 days of receipt of this memorandum.

2. If the Licensee cannot obtain the personnel monitoring records for Michelle Dingle, a dose assessment must be made and a copy of the assessment submitted to the Agency, within 30 days of receipt of this memorandum.

3. The Licensee shall institute a written tracking procedure that must include nuclear pharmacy records, physician records, etc., to ensure that doses are not lost. A copy of this tracking procedure must be submitted to the Agency within 30 days of receipt of this memorandum.

4. The Agency will increase the Licensee's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Licensee's and Numed, Inc.'s representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Harris Methodist Hospital - Ft. Worth, dba: Doris Kupferle Breast Center - Ft. Worth, Texas - Mammography

On February 17, 2000, an Enforcement Conference was held with Harris Methodist Hospital - Ft. Worth, dba: Doris Kupferle Breast Center. Registrant representatives attending the conference were Messrs. Barclay Berdan, Jeff Layne, and John B. Tauser, and Madames Dede Dickinson, Jeanne T. Reardon, and Wanda Hall. Agency representatives attending the conference were Messrs. Rick Muñoz (Chair), Tom Godard, Jerry Cogburn, and Thomas Caldwell and Messrs. Leanne Myers, Jo Turkette, and Cathy McGuire.

The conference was held as a result of the type, number, severity level, and repetitive nature of violations noted during an Agency inspection conducted at the Registrant's facility on October 20, 1999.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Jerry Cogburn.

After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Agency will increase the Registrant's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections.

2. The Registrant's representatives expressed concern regarding credential requirements on mobile mammography units being assessable to possible duplication. An Agency representative will talk to the appropriate Board to see if optional recourse is available to deal with the possibility that credentials would be unsecured on the mobile mammography units. This Agency will advise the Registrant of options available.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Robert Silva, M.D., P.A., dba: San Antonio Neurology Offices - San Antonio, Texas - Medical

On February 22, 2000, an Enforcement Conference was held with Roberto Silva, M.D., P.A., dba: San Antonio Neurology Offices. The Registrant's representative attending the conference was Roberto Silva, M.D. Agency representatives attending the conference were Messrs. Quincy Wickson (Chair) and Rick Munoz and Madames June Ayers and Cathy McGuire.

The conference was held as a result of the type, number, severity level, and repetitive nature of violations noted during Agency inspections conducted at the Registrant's facility.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notices of Violation, and the responses to the violations, were reviewed by Ms. June Ayers.

After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Registrant shall submit to the Agency a written response to each violation within 45 days of receipt of this memorandum. This response must include: a copy of the technique chart; a copy of the operating and safety procedures; and a copy of the maintenance schedule.

2. The Registrant shall submit to the Agency a written commitment that the duties and responsibilities of the radiation safety officer (RSO) will be reviewed with the current RSO within 45 days of receipt of this memorandum. If a new RSO is assigned, the individual's qualifications must be submitted to the Agency.

3. The Registrant shall submit to the Agency a copy of the medical physicist's completed report within 45 days of receipt of this memorandum.

4. An unannounced reinspection will occur after completion of these corrective actions. Failure to comply or if the reinspection determines that the corrective actions were not adequately performed, a $12,000.00 penalty will be assessed by the Agency.

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. He agreed to these items and the conference was concluded.

Enforcement Conference: Berry Fabricators - Corpus Christi, Texas - Industrial Radiography

On February 29, 2000, an Enforcement Conference was held with Berry Fabricators. Licensee representatives attending the conference were Messrs. Charles Good and James Coulter. Agency Representatives attending the conference were Messrs. Rick Muñoz (Chair), David Fogle, and Bob Green and Ms. Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Licensee's facility on December 2, 1999, and a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Bob Green.

After reviewing the violation and response, the Licensee's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Licensee shall furnish, by April 10, 2000, a copy of their inspection and maintenance form, information form, and content/implementation audit form for their Radiation Protection Program.

2. The Agency will increase the Licensee's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Licensee's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Cyvon Imaging, Inc., dba: Community Diagnostics - Dallas, Texas - Mammography

On March 7, 2000, an Enforcement Conference was held with Cyvon Imaging, Inc. dba: Community Diagnostics. Registrant representatives attending the conference were Mr. Bob McHenry and Ms. Yvonne McHenry. Agency Representatives attending the conference were Messrs. Rick Muñoz (Chair), Jerry Cogburn, and Thomas Caldwell and Ms. Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Registrant's facility on December 3, 1999, and a significant, unacceptable deficiency in the application and overall effectiveness of their radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Jerry Cogburn.

After reviewing the violation and response, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Registrant failed to cease utilizing the darkroom immediately after the darkroom fog test indicated the fog density limit had been exceeded. The registrant shall provide the Agency a copy of the darkroom fog tests results, by April 1, 2000.

2. The Registrant failed to document a quality assurance program specific to Mammographic imaging. Policy and procedures must be provided to the Agency by April 1, 2000 and must include: densitometer and sensitometer corrections to their manual; an audit for pathology; a processor maintenance log; a procedure for quarterly review by Dr. Nelson; and a policy to discontinue the use of the Rodium filter.

3. The Agency will require the lead interpreting physician to review the mammography quality control documents on a monthly basis, beginning on April 1, 2000, and continuing for one year. Documentation must be provided to the Agency to verify compliance.

4. The Agency will increase the Registrant's inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Registrant's representatives were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Showtech Production, Inc. - Grand Prairie, Texas - Laser

On March 8, 2000, an Enforcement Conference was held with Showtech Production, Inc. The Registrant's representative attending the conference was Mr. Keith Kettrey. Agency representatives attending the conference were Messrs. Rick Muñoz (Chair), and Thomas Caldwell and Madames Karan Rains, Latisha Merritt, Irma Gonzales, and Cathy McGuire.

The conference was held as a result of an Agency inspection conducted at the Registrant's facility on December 3, 1999, that determined the Registrant performed a laser light show without a certificate of registration.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Ms. Karan Rains.

After reviewing the violation and response, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. A Cease and Desist Order was rescinded.

2. The Registrant shall submit written notification to the Agency, at least 7 days prior to any laser light show performance, and receive written approval from the Agency prior to any laser light show performance.

3. The Registrant performed two laser lights shows even though the facility was not registered. Administrative penalties in the amount of $5,000 were assessed. The first violation occurred during the time period when the Registrant was not registered and a penalty of $2,000 was assessed. The second violation occurred while the Registrant was unregistered and under a Cease and Desist Order to not perform laser light shows. A penalty of $3,000 was assessed for this occurrence.

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. He agreed to these items and the conference was concluded.

Enforcement Conference: Doctor's Hospital Tidwell - Tidwell, Texas - Mammography

On March 14, 2000, an Enforcement Conference was held with Doctors Hospital Tidwell. Registrant representatives attending the conference were Mr. Carlos Muñoz and Ms. Pushpa Thomas. Agency Representatives attending the conference were Messrs. Rick Muñoz (Chair) and Jerry Cogburn and Ms. Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Registrant's facility on January 27, 2000,and a significant, unacceptable deficiency in the application and overall effectiveness of their radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Jerry Cogburn.

After reviewing the violation and response, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Registrant shall notify all patients who received procedures during the period of April 13, 1999, through January 27, 2000. The notification letter must be approved by the Agency prior to posting.

2. The lead interpreting physician shall conduct and document a monthly review of the mammography quality control program for a period of one year. The physician's review must be available for review by Agency inspectors.

3. The Registrant shall provide the Agency with a strategy of implementation for a check and balance system to ensure overview of the mammography quality control program.

4. The Agency will increase the Registrant's inspection frequency and administrative penalties may be assessed pending the results of these inspections.

5. It was determined the Registrant may remove the Notice of Failure currently posted at their facility. An Agency letter was provided to the Registrant indicating that the response provided during the enforcement conference was adequate and brought the facility into compliance.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Image Imprinter's, Inc., dba: Plano Diagnostic Imaging Center - Plano, Texas - Mammography

On March 21, 2000, an Enforcement Conference was held with Image Imprinters, Inc, which was bought by Healthsouth. The Registrant's representative attending the conference was Ms. Cynthia Railsback. Agency Representatives attending the conference were Messrs. Rick Muñoz (Chair), Thomas Caldwell, and Jerry Cogburn and Ms. Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Registrant's facility on January 20, 2000,and a significant, unacceptable deficiency in the application and overall effectiveness of their radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Jerry Cogburn.

After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. A Notice of Violation will be issued to Healthsouth, because they bought Image Imprinters, citing the Registrant for failure to provide notification to the Agency within 30 days of a change of radiation safety officer, interpreting physician, and address.

2. The Registrant shall provide written notification of change of ownership of Image Imprinters, Inc. to Healthsouth.

3. A Cease and Desist Order will be issued to the Registrant unless the Agency receives notification of the change of interpreting physician and documentation of required credentials by March 30, 2000.

4. The Registrant shall implement and provide documentation of a Quality Assurance Program Committee review on a monthly basis to begin April 1, 2000, and continue for one year. The Committee will be comprised of the interpreting physician, Ms. Railsback, and the mammography technician.

5. The Agency will increase the Registrant's inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Doctor's Hospital 1997 L.P. - Houston, Texas - Medical

On March 30, 2000, an Enforcement Conference was held with Doctor's Hospital 1997 LP, dba: Doctor's Hospital Parkway. The Registrant's representative attending the conference was Chuck Neas, Director of Radiology. Agency representatives attending the conference were Messrs. Quincy M. Wickson (Chair), Rick Munoz, and Thomas Caldwell and Madames Jackie Carter and Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during Agency inspections conducted at the Registrant's facility.

The participants were introduced and the procedure for conducting the conference was explained.

The violations stated in the Notices of Violation, and the responses to the violations, were reviewed by Ms. Jackie Carter.

After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Registrant shall submit a written commitment to the Agency, within 30 days of receipt of this memorandum, detailing the steps taken to ensure that corrective actions will be taken within 30 days of receipt of any adverse findings on a Medical Physicist's report or any violation cited in a Notice of Violation.

2. The Registrant shall submit a copy of the training criteria for technologists within 30 days of receipt of this memorandum.

3. The Registrant shall submit a written commitment to the Agency, within 30 days of receipt of this memorandum, that the x-ray machine in Room 1 will be monitored on a monthly basis due to the recurring problems encountered with this machine.

4. The Registrant shall submit a written commitment within 30 days of receipt of this memorandum that the radiation safety officer will review all documentation related to radiation safety and sign off on these documents.

5. The Registrant shall submit a copy of the darkroom light leak test result within 30 days of receipt of this memorandum.

6. The Agency will increase the Registrant's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. He agreed to these items and the conference was concluded.